

Medical Assistance Administration



Hearing Aids & Services

Billing Instructions

[WAC 388-544]

October 2003

About this publication

This publication supersedes all previous Hearing Aids & Services Program Billing Instructions and the following Numbered Memoranda 00-63 MAA, 01-40 MAA, 02-51 MAA, and 03-21 MAA.

You may request a copy of the law relating to Hearing and Speech (18.35 RCW) from:

Washington State Department of Health
Board of Hearing and Speech
PO Box 47869
Olympia, WA 98504-7869

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Washington State Department of Social and Health Services
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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2))

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call Provider Enrollment
Toll-Free: (866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Internet billing?

<http://maa/dshs/wa.gov>
[Open the "Electronic Claims Submission" link in left-hand Table of Contents]

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's website:
<http://maa.dshs.wa.gov>

Where do I call/write if I have questions regarding...

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Medical Assistance
Customer Service Center
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Division of Customer Support
Coordination of Benefits Section
1-800-562-6136

Limitation Extensions

Division of Medical Management (DMM)
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Telephone (360) 725-1583
Fax (360) 586-1471

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Definitions

This section defines terms and acronyms used in these billing instructions.

Children with Special Health Care Needs (CSHCN) – Children with disabilities or handicapping conditions; chronic illnesses or conditions; health related educational or behavioral problems; or children at risk of developing such disabilities, conditions, illnesses or problems. [WAC 246-710-010]

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Code of Federal Regulations (CFR) - Rules adopted by the federal government. [WAC 388-500-0005]

Community Services Office (CSO) - An office of the department's economic services administration that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Deafness - Complete or partial loss of ability to hear.

Department - The state Department of Social and Health Services. [WAC 388-500-0005]

Digital hearing aids – Hearing aids with a digital signal processor inside that converts analog sound into a digital code that allows for enhanced ability to amplify speech over background noise. *All digital hearing aids are programmable, but not all programmable hearing aids are digital.*

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) -

Also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. [WAC 388-500-0005]

Expedited Prior Authorization (EPA) – The process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services. [WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

FM Systems – A hearing device that uses a frequency modulated radio signal. FM systems are sometimes referred to as radio frequency (RF) aids. [WAC 388-544-1010]

Health, Department of – The Washington state department responsible for preserving public health, monitoring health care costs, maintaining minimal standards for quality in health care delivery, and generally overseeing and planning the state's activities as they related to the health of its citizenry. [WAC 246-01-001]

Hearing Aid - A device that amplifies sound and which does not discriminate between wanted and unwanted sound, nor rectify sound distortion experienced by most hearing impaired clients.

Limitation Extension – A process for requesting reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization. [WAC 388-500-0005]

Local CSHCN Agency – The local health jurisdiction or other agency locally administering the CSHCN program for the county where the client resides in the state of Washington. [WAC 246-710-010]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable Fee - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment. [WAC 388-544-1010]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
 - Medically needy program.
- [WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities. [WAC 388-500-0005]

Medical Identification card – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards. [WAC 388-500-0005]

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

OCSHCN - The Department of Health's Office of Children with Special Health Care Needs.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Prior Authorization – A process by which clients or providers must request and receive MAA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.
[WAC 388-500-0005]

Programmable hearing aids – Hearing aids that can be “programmed” digitally by a computer. *All digital hearing aids are programmable, but not all programmable hearing aids are digital.*

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance And Status Report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.
[WAC 388-500-0005]

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.
[WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- 1) The usual and customary charge that you bill the general public for the same services; or
- 2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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Hearing Aids Program

About the program

[Refer to WAC 388-544-1100]

- MAA covers only the hearing aid services listed in this billing instruction, subject to exceptions, restrictions, and limitations as noted.
- MAA evaluates requests for services listed as noncovered or subject to limitations or other restrictions according to the provisions in WAC 388-501-0165.
- MAA reimburses providers at the maximum allowable rates listed in this billing instruction (see Section G: Fee Schedule).

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Client Eligibility

Who is eligible?

[Refer to WAC 388-544-1200]

Clients presenting Medical IDentification cards with one of the following identifiers are eligible for hearing aid services:

Medical Identifier	Medical Program
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
CNP-QMB	CNP-Qualified Medicare Beneficiary
GAU – No out of state care	General Assistance – Unemployable
General Assistance – No out of state care	ADATSA, ADATSA Medical Only
LCP-MNP (Only for clients through 20 years of age. See note below.)	Limited Casualty Program – Medically Needy Program



Note: Clients 18 through 20 years of age must either be referred by a screening provider under the EPSDT program or meet the requirements on page C.1.

When a client is referred by a screening provider under the EPSDT program, you must include the referring provider number in field 17a on the HCFA-1500 claim form. If no MAA provider number is available, enter the referring provider's name in field 17. Keep referral information in the client's file.

Are hearing aid services covered under MAA's managed care plans?

Hearing aid services are not covered under MAA's managed care plans. Clients enrolled in an MAA managed care plan **may** be eligible for hearing aid services if they meet the eligibility criteria. Hearing aid equipment and services are reimbursed through the fee-for-service system. This billing instruction contains eligibility criteria, coverage information, and billing guidelines.

Coverage - Adults

What is covered for adults?

[Refer to WAC 388-544-1200]

Purchase

MAA covers the **purchase** of one new, non-refurbished hearing aid for an adult client every 5 years if all of the following conditions are met:

- The client must:
 - ✓ Be 18 years of age or older;
 - ✓ Present a DSHS Medical Identification Card with a valid medical identifier (see Section B: Client Eligibility);
 - ✓ Have an average hearing of 50 dBHL or worse in the better ear based on auditory screening by a certified audiologist or licensed hearing instrument fitter/dispenser at 1000, 2000, 3000, and 4000 Hertz (Hz) with effective masking as indicated.
- The client's current hearing aid (if the client has one) is not sufficient for the hearing loss in the better ear.
- The hearing aid must be:
 - ✓ Medically necessary; and
 - ✓ Warranted for one year.



Note: Reimbursement for adult hearing aids includes:

- A prefitting evaluation;
- An ear mold; and
- A minimum of three post-fitting consultations.

Repair

MAA covers the **repair** of a hearing aid when the:

- ✓ Initial one-year warranty has expired;
- ✓ Client continues to meet the criteria for eligibility (see Section B) and purchase (see page C.1);
- ✓ Cost of repair is less than 50% of the cost of a new hearing aid;
- ✓ Provider has documented the repair and replacement costs; and
- ✓ Repair is warranted for 90 days.


Rental

MAA covers the cost of renting a hearing aid for up to two months while the client's own hearing aid is being repaired. When billing MAA, **use the appropriate HCPCS code with modifier RR**.

Replacement

MAA covers **one replacement hearing aid** (which includes ear mold and/or casing) in a 5-year period when the:

- ✓ Hearing aid is lost or broken beyond repair;
- ✓ Client continues to meet the criteria for eligibility (see Section B) and purchase (see page C.1); and
- ✓ Provider has documented the necessity for the replacement in the client's file.

 **Note:** When billing for a one-time, replacement hearing aid within a five-year period, **use modifier RP (replacement)** with the appropriate procedure code. Refer to Section G: Fee Schedule

MAA covers **replacement of ear molds** as follows:

- ✓ Once a year for soft ear molds; and
- ✓ Once every three years for hard ear molds.

What is not covered for adults?

[Refer to WAC 388-544-1400]

MAA does not cover any of the following:

- The purchase of batteries, ear trumpets, or tinnitus maskers;
- Group screenings for hearing loss;
- Hearing aid charges reimbursed by insurance or other payer source;
- Digital hearing aids;
- FM Systems; or
- Programmable hearing aids.

Exception To Rule (ETR)

MAA evaluates a request for medical services, equipment, and/or supplies that are listed as noncovered under the provisions of WAC 388-501-0160 that relates to noncovered services. The request for a noncovered medical service, equipment, or supply is called a “request for an exception to rule.” See WAC 388-501-0160 for information about exceptions to rule.

In order to request an ETR, you must fill out and return to MAA the Exception to Rule Information Sheet found on the next page (or a form with similar information):

Division of Medical Management
ATTN: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Telephone (360) 725-1583
Fax (360) 586-1471

Request for Exception to Rule When EPA Criteria Does Not Apply

Provider Information

Name: _____ Provider # _____
Phone: _____ Fax: _____

Client Information

Name: _____ PIC: _____
ie (AB-122300-SMITH-A)

Service Request Information

Description of service with Diagnosis and Procedure codes

Additional Information

Please provide the following information:

1. Copy of current audiogram for both ears, aided and unaided
2. Copy of Baseline audiogram (If Applicable)
3. Date MAA purchased last hearing device
4. Currently wearing:

Single _____ Binaural _____ How Long? _____

5. Copy of MD Prescription

What is the clinical justification for this request :

Coverage - Children

Per chapter 388-544 WAC, clients 17 years of age and younger who require hearing aid services must be referred to the Department of Health's Children with Special Health Care Needs (CSHCN) program. The CSHCN coordinator prior authorizes hearing aid equipment and services for MAA-eligible children by verifying medical necessity from information supplied by the provider before the equipment is dispensed. **Prior authorization does not guarantee payment. Eligibility requirements must still be met.** The provider is responsible for following billing instructions in order to receive payment from MAA.

What is covered for children?

[Refer to WAC 388-544-1300]

Purchase

MAA covers the **purchase** of new, non-refurbished hearing aids for clients if all of the following conditions are met:

- The client must:
 - ✓ Be 17 years of age and younger;
 - ✓ Present a Medical ID card with a valid medical identifier (see Section B: Client Eligibility); and
 - ✓ Have prior authorization from the child's local Department of Health's (DOH) CSHCN coordinator to receive a hearing aid. (See Section E: Authorizations)
- The hearing aid must be:
 - ✓ Medically necessary; and
 - ✓ Warranted for one year.



Note: Provider reimbursement for children's hearing aids includes all of the following:

- A prefitting evaluation;
- An ear mold for in the ear (ITE) hearing aids; and
- A minimum of three post-fitting consultations.

Repair

MAA covers the **repair** of a hearing aid when the:

- ✓ Client's local CSHCN coordinator authorizes the repair;
- ✓ Initial one-year warranty period has expired;
- ✓ Client continues to meet the criteria for eligibility (see Section B) and purchase (see page D.1);
- ✓ Cost of repair is less than 50% of the cost of a new hearing aid;
- ✓ Provider has documented the repair and replacement costs; and
- ✓ Repair is warranted for 90 days.

Rental

MAA covers the cost of renting a hearing aid for up to 90 days while the client's own hearing aid is being repaired when the rental is authorized by the client's local CSHCN coordinator. Bill the appropriate **HCPCS procedure code with modifier RR**.

Replacement

- MAA covers **replacement of a hearing aid** when the:
 - ✓ Client's local CSHCN coordinator authorizes the replacement;
 - ✓ Client continues to meet the criteria for eligibility (see Section B) and purchase (see page D.1);
 - ✓ Hearing aid is lost or broken beyond repair; and
 - ✓ Provider has documented the necessity for the replacement.
- MAA covers **replacement of hard and soft ear molds** when the replacement is authorized by the client's local CSHCN coordinator.

What is not covered for children?

[Refer to WAC 388-544-1400]

MAA does not cover any of the following:

- Purchase of batteries, ear trumpets, or tinnitus maskers;
- Group screenings except as provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program under WAC 388-534;
- Computer-aided hearing devices used in school;
- Hearing aid charges reimbursed by insurance or other payer source;
- Digital hearing aids; or
- FM systems or programmable hearing aids when the device is used in school, or when the child's hearing loss is adequately improved with hearing aids.

Exception To Rule (ETR)

MAA evaluates a request for medical services, equipment, and/or supplies that are listed as noncovered under the provisions of WAC 388-501-0160 that relates to noncovered services. The request for a noncovered medical service, equipment, or supply is called a "request for an exception to rule." See WAC 388-501-0160 for information about exceptions to rule.

In order to request an ETR, you must fill out and return to MAA the Exception to Rule Information Sheet found on the next page (or a form with similar information):

Division of Medical Management
ATTN: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Telephone (360) 725-1583
Fax (360) 586-1471

Request for Exception to Rule When EPA Criteria Does Not Apply

Provider Information

Name: _____ Provider # _____
Phone: _____ Fax: _____

Client Information

Name: _____ PIC: _____
ie (AB-122300-SMITH-A)

Service Request Information

Description of service with Diagnosis and Procedure codes

Additional Information

Please provide the following information:

1. Copy of current audiogram for both ears, aided and unaided
2. Copy of Baseline audiogram (If Applicable)
3. Date MAA purchased last hearing device
4. Currently wearing:

Single _____ Binaural _____ How Long? _____

5. Copy of MD Prescription

What is the clinical justification for this request :

Authorization

What is prior authorization?

Prior authorization is MAA and/or Department of Health approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

Prior Authorization for Children

Prior authorization is required for all hearing aid equipment or services for children. The local Children with Special Health Care Needs (CSHCN) coordinator in the county where the client resides (see page H.1) authorizes all hearing aid equipment or services for children except FM Systems. FM Systems are authorized by the Medical Assistance Administration (MAA) through the Expedited Prior Authorization (EPA) process.

Requesting prior authorization from the client's local CSHCN coordinator

Prior to dispensing equipment and/or related services, providers must send a completed HCFA-1500 claim form, including all backup documentation, to the local CSHCN coordinator (see page H.1). Each requested item or service must be identified using the appropriate procedure code.

1. The CSHCN coordinator reviews the request to verify that required otological and audiological examinations have been provided and certifies the medical necessity of requested equipment or service.
2. If results of the examinations show the criteria have been met, the CSHCN coordinator puts the CSHCN stamp and his or her signature in *field 23* of the HCFA-1500 claim form.
3. The CSHCN Coordinator approves by initialing each authorized line item (equipment or service) in *field 24K* of the HCFA-1500 claim form. If the CSHCN coordinator does not initial a line item, MAA will deny payment for that line item.

4. The CSHCN coordinator returns the form to the provider, who may proceed to dispense the equipment and/or services authorized by the CSHCN coordinator. A copy of the list of authorized equipment and/or services will be kept by the CSHCN coordinator.
5. After the hearing aid equipment has been dispensed or the approved service provided, the provider bills MAA by submitting the HCFA-1500 claim form stamped, signed, and initialed by the local CSHCN coordinator. (See “Important Contacts” for billing address.) The provider is responsible for following MAA billing instructions to receive payment.

Prior Authorization for Adults

Prior authorization is required for adults for the following services:

1. Bone conduction hearing aids; and
2. Binaural hearing aids.

How do I obtain prior authorization?

When requesting prior authorization for one of the above services, fill out and return to MAA the Fax/Written Request form found on the next page (or a form with similar information).

Send or fax your request to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

Fax\Written Request Basic Information

Provider Information

Name _____ Provider #: _____
Phone _____ Fax: _____

Client Information

Name _____ PIC - - -

ie (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

Procedure Number units number units
Code _____ requested _____ used this year _____

Medical Information

Dates of injury or illness _____
Diagnosis code _____ Diagnosis name _____
Place of service _____
How will approving this request change the course of treatment?

Goal of treatment? _____

What is the clinical justification for this request (if not addressed above?)

Please send in any necessary additional documentation with your request to:

Fax: **360-586-1471** or mail to: Attn: Medical Request Coordinator
MAA – Division of Medical Management
PO Box 45506
Olympia, WA 98504-5506

What are Limitation Extensions?

Limitation extensions are cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administration Code (WAC).



Note: Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups receive all services.

How do I request a limitation extension?

There are two ways to request a limitation extension:

- 1) Providers may be able to obtain authorization for these limitation extensions using an expedited prior authorization number. These EPA numbers will be subject to post payment review as in any other authorization process. (See "What is Expedited Prior Authorization," page E.4.)
- 2) In cases where the client's situation does not meet the EPA criteria for a limitation extension, but the provider still feels that additional services are medically necessary, the provider must request MAA approval in writing. A request form has been provided for your convenience. (See Exception to Rule, page C.3 & D.3.)

The request must state the following in writing:

1. The name and PIC of the client;
2. The provider's name, MAA provider number, telephone number, and FAX number;
3. Additional service(s) requested;
4. Copy of current audiogram for both ears aided and unaided, and the date the last hearing aid(s) were dispensed;
5. The primary diagnosis with the HCPCS code for the requested item; and
6. Clinical justification for additional item(s).

Send your written request for a limitation extension to:

Division of Medical Management (DMM)
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Telephone (360) 725-1583
Fax (360) 586-1471

What is Expedited Prior Authorization?

Expedited prior authorization (EPA) numbers are designed to eliminate the need for written authorization. MAA establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an “EPA” number using those codes.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **form a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages E.5 and E.6 for codes). Enter the EPA number on the billing form in *field 23* when billing for adults and *field 19* when billing for children, or in the *Authorization* or *Comments* field when billing electronically. **(Do not put the EPA # in field 23 when billing for children because the CHSCN Coordinators use that field for their signature stamp.)**

Example: The 9-digit authorization number for an exam for a 25 year old client whose average hearing is 40 dBHL in the 1000-4000 Hertz (Hz) and is legally blind would be **870000600**.

870000 = first six digits of all expedited prior authorization numbers
600 = last three digits of an EPA number indicating the service and which criteria the case meets.

- MAA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.
- The billing provider must document in the client’s file how expedited prior authorization criteria was met, and make this information available to MAA on request.

EPA – Limitation Extension for Adults

Hearing Aids - Adults

Procedure Codes: V5050, V5060

600 **Initial Hearing Aid** for clients 18 years of age and older, when auditory screening shows an average hearing of 50 dBHL or worse in one ear at 1000, 2000, 3000 and 4000 Hz and has one or more of the following documented in the client's medical records:

1. Inability to hear has caused difficulty with job performance;
2. Inability to hear has caused difficulty in functioning in the school environment; or
3. Client is legally blind.

601 **Second Hearing Aid** for clients 18 years of age and older, who have tried to adapt with one hearing aid for a period of 6 months, whose auditory screening shows an average hearing of 50 dBHL or worse in both ears at 1000, 2000, 3000, and 4000 Hz and has one or more of the following documented in the client's records:

1. Inability to hear has caused difficulty with job performance;
2. Inability to hear has caused difficulty in functioning in the school environment; or
3. Client is legally blind.

EPA – Limitation Extension for Children

Programmable Hearing Aids - Children

Procedure Codes: V5246, V5247, V5252, V5253

605 **Programmable Hearing Aid** for a client 2-17 years of age, when prescribed by an audiologist and **at least one** of the following criteria is documented in the client's medical records:

1. The hearing loss pattern varies significantly or fluctuates from frequency to frequency (more than a 20 dBHL difference between octave bands).
2. Client has progressive hearing loss.
3. Client has developmental delays and is unable to give reliable test responses.
4. Client has physical or developmental disabilities and cannot adjust controls independently.
5. Background noise, discrimination problems, or recruitment are particularly problematic in the client.
6. Before and after testing, the client has demonstrated the effectiveness of a programmable aid(s) over regular hearing aid(s).

FM System - Children

Procedure Code: V5274

606 **FM System** for clients 2-17 years of age with the following documented in the client's records:

1. Completed comprehensive clinical testing with and without an FM system **or** proven successful use of an FM system in school; **and**
2. A diagnosis of apraxia, severe bilateral hearing loss not adequately benefited with hearing aids, auditory neuropathy, other "central" processing problems, **or** multiple handicaps; **and**
3. Average hearing of 50 dBHL or worse at 1000, 2000, 3000, and 4000 Hz.; **and**
4. Prescribed by an audiologist.

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Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

- ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders MAA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.
- ✓ MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive² period; or
 - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

² **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

- ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at <http://maa.dshs.wa.gov/> or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept in the client's file?

Specific to the Hearing Aids & Services Program, documentation of all hearing tests and results must be kept in the complete client's chart and record.

This includes, but is not limited to, the following tests:

- Audiogram results/graphs/tracings (including air conduction and bone conduction comparisons);
- Basic or simple hearing tests or screening, such as is done in many schools;
- Tympanogram;
- Auditory Brainstem Response (ABR); and
- Electronystagmogram (ENG) (not a hearing test but a special test of inner ear balance).

[Refer to WAC 388-502-0020]

In general, enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications, equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ X-rays, tests, and results;
 - ✓ Plan of treatment and/or care, and outcome; and
 - ✓ Specific claims and payments received for services.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

Fee Schedule

Hearing Aids for Adults and Children

Services and/or equipment for adults must meet program requirements.

*Children's hearing aid equipment and services
REQUIRE authorization from the client's local CSHCN coordinator.*

Procedure Code	Description	Adult	Child	Modifier	10/1/03 Maximum Allowable
V5014	Repairs (includes parts and labor) or Hearing Aid Casing (replacement only); casing allowed no more than once in 5 years	X	X	RP (for casing only)	\$80.48
V5030	Hearing aid, monaural, body worn, air conduction	X	X	RT, LT, or RP	523.82
V5040	Hearing aid, monaural, body worn, bone conduction (requires prior authorization when dispensed to adults)	X	X	RT, LT, or RP	523.82
V5050	Hearing aid, monaural, in the ear (ITE)	X	X	RT, LT, RP, or RR	purchase: 459.92 rental: 38.88
V5060	Hearing aid, monaural, behind the ear (BTE)	X	X	RT, LT, RP, or RR	purchase: 465.07 rental: 38.88
V5100	Hearing aid, bilateral, body worn (requires prior authorization when dispensed to adults)	X	X		942.79
V5130	Hearing aid, binaural, ITE (requires prior authorization when dispensed to adults)	X	X		881.72
V5140	Hearing aid, binaural, BTE (requires prior authorization when dispensed to adults)	X	X		960.68

Modifiers

ON-LINE UPDATE 10/22/03

LT = Left

RT = Right

RP = Replacement

RR = Rental

Hearing Aids & Services

Procedure Code	Description	Adult	Child	Modifier	10/1/03 Maximum Allowable
V5246	Hearing aid, digitally programmable analog, monaural, ITE (covered only when approved as a limitation extension)		X		\$1,070.25
V5247	Hearing aid, digitally programmable analog, monaural, BTE (covered only when approved as a limitation extension)		X		1,070.25
V5252	Hearing aid, digitally programmable, binaural, ITE (covered only when approved as a limitation extension)		X		1,987.24
V5253	Hearing aid, digitally programmable, binaural, BTE (covered only when approved as a limitation extension)		X		1,987.24
V5264	Ear mold/insert, not disposable, any type; (for adults: replacement only, allowed no more than once in 3 years)	X	X	RP (for adults only)	38.49
V5274	Assistive learning device, not otherwise specified (requires prior authorization)		X		2,277.04

Please bill your usual and customary charge.

Payment will be the lesser of billed charge or the maximum allowable fee.

Modifiers

LT = Left

RT = Right

RP = Replacement

RR = Rental

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) LOCAL AGENCY COORDINATORS AND SUPPORT STAFF

(Street addresses in parenthesis are only used for package deliveries by
carriers other than the U.S. Postal Service.)

County	Contact/Address	Communications
<i>Adams County Health District</i>	108 West Main Ritzville, Washington 99169	(509) 659-3317 ◆ FAX (509) 659-4109
<i>Asotin County Health District</i>	431 Elm Street Clarkston, Washington 99403	(509) 758-3344/3345 ◆ FAX (509) 758-8454
<i>Benton-Franklin Health District</i>	800 West Canal Drive Kennewick, Washington 99336	(509) 586-0207, ext. 236 ◆ FAX (509) 585-1525
<i>Bremerton-Kitsap County Health District</i>	109 Austin Drive Bremerton, Washington 98312	(360) 478-5235 ◆ FAX (360) 478-5298
<i>Chelan-Douglas Health District</i>	200 Valley Mall Parkway East Wenatchee, Washington 98802 <i>For mailing address, use the following:</i> PO Box 429 Wenatchee, Washington 98807	(509) 886-6400 ◆ FAX (509) 886-6478
<i>Clallam County Department of Health & Human Services</i>	223 East Fourth Street (PO Box 863) Port Angeles, Washington 98362-0149	(360) 417-2439 ◆ FAX (360) 417-2519
<i>Columbia County Health District</i>	221 East Washington, Suite 101PH Dayton, Washington 99328	(509) 382-2181 ◆ FAX (509) 382-2942
<i>Cowlitz County Health Department</i>	600 Broadway, Third Floor Longview, Washington 98632 <i>For mailing address, use the following:</i> 207 Fourth Avenue North Kelso, Washington 98626-4124	(360) 414-5599 ◆ FAX (360) 425-7531
<i>Garfield County Health District</i>	Post Office Box 130 (10th & Columbia) Pomeroy, Washington 99347	(509) 843-3412 ◆ FAX (509) 843-1935
<i>Grant County Health District</i>	1021 West Broadway Moses Lake, WA 98837	(509) 766-7960 ◆ FAX (509) 766-6519
<i>Grays Harbor Health Department</i>	2109 Sumner Avenue Aberdeen, Washington 98520	(360) 532-8631 ◆ FAX (360) 533-6272

** Indicates Regional Representative

◆ FAX or Internet not located in agency office.

Hearing Aids & Services

County	Contact/Address	Communications
<i>Island County Health Department</i>	Post Office Box 5000 (410 North Main Street) Coupeville, Washington 98239	(360) 679-7351 ◆ FAX (360) 679-7347
<i>Jefferson County Health and Human Services</i>	615 Sheridan, Castlehill Center Port Townsend, Washington 98368	(360) 385-9400 ◆ FAX (360) 385-9401
<i>Kittitas County Health Department</i>	507 Nanum Street, Room 102 Ellensburg, Washington 98926	(509) 962-7635 ◆ FAX (509) 962-7581
<i>Klickitat County Health Department</i>	Post Office Box 159 (170 NW Lincoln) White Salmon, Washington 98672	White Salmon 1-888-267-1199 ◆ FAX (509) 493-4025 Goldendale 1-888-291-3521
<i>Lewis County Health Department</i>	360 N.W. North Street M.S. HSD03 Chehalis, Washington 98532	(360) 740-1383 ◆ FAX (360) 621-1472
<i>Lincoln County Public Health Coalition</i>	90 Nicholls Street Davenport, Washington 99122	(509) 725-1000, ext. 26 ◆ FAX (509) 725-1014
<i>Mason County Health Department</i>	303 North Fourth Street Shelton, Washington 98584	(360) 427-9670, Ext. 408 ◆ FAX (360) 427-7787
<i>N.E. Tri-County Health District Pend Oreille County</i>	Post Office Box 490 (230 South Garden) Newport, Washington 99156	(509) 447-3131 ◆ FAX (509) 447-5644
<i>N.E. Tri-County Health District Stevens County</i>	Post Office Box 270 (240 East Dominion Street) Colville, Washington 99114	(509) 684-5048 ◆ FAX (509) 684-1002
<i>N.E. Tri-County Health District Ferry County</i>	Post Office Box 584 (470 North Clark Ave, Suites 11 & 12) Republic, Washington 99166	(509) 775-3111 ◆ FAX (509) 775-2858
<i>Okanogan County Health District</i>	Post Office Box 231 (1234 South Second) Okanogan, Washington 98840	(509) 422-7140 1-800-222-6410 ◆ FAX (509) 422-7384
<i>Pacific County Health Department</i>	Post Office Box 26 (1216 W Robert Bush Drive) South Bend, Washington 98586	(360) 875-9343 ◆ FAX (360) 875-9323
<i>San Juan County Health Department</i>	Post Office Box 607 (145 Rhone Street) Friday Harbor, Washington 98250-0607	(360) 378-4474 ◆ FAX (360) 378-7036
<i>Public Health – Seattle & King County</i>	999 Third Avenue (MS: FIC-PH-0905) Seattle, Washington 98104-4039	(206) 296-4610 ◆ FAX (206) 296-4679

** Indicates Regional Representative

◆ FAX or Internet not located in agency office.

Hearing Aids & Services

County	Contact/Address	Communications
<i>Skagit County Health Department</i>	700 South Second, Room 301 Mount Vernon, Washington 98273	(360) 336-9380 ◆ FAX (360) 336-9401
<i>Snohomish Health District</i>	3020 Rucker Avenue, #200 Everett, Washington 98201	(425) 339-5240 ◆ FAX (425) 339-5255
<i>Southwest Washington Health District</i> (Clark and Skamania Counties)	Post Office Box 1870 (2000 Fort Vancouver Way, Zip 98663) Vancouver, Washington 98668	(360) 397-8472 ◆ FAX (360) 397-8424
<i>Spokane Regional Health District</i>	West 1101 College Avenue Spokane, Washington 99201	(509) 324-1697 ◆ FAX (509) 324-1699
<i>Tacoma-Pierce County Health Department</i>	3629 South "D" Street, MS 092 Tacoma, Washington 98408 Mary Bridge Children's Health Center 311 South "L" Street Tacoma, Washington 98415	(253) 798-6517 ◆ FAX (253) 798-4787 (253) 403-4799 ◆ FAX (253) 403-1540
<i>Thurston County Health Department</i>	529 West Fourth Street (MS: 0947) Olympia, Washington 98501	(360) 754-3351 ◆ FAX (360) 786-5594
<i>Wahkiakum County Health Department</i>	Post Office Box 696 (64 Main Street) Cathlamet, Washington 98612	(360) 795-6207 ◆ FAX (360) 795-6143
<i>Walla Walla County-City Health Department</i>	Post Office Box 1753 (310 West Poplar) Walla Walla, Washington 99362-0346	(509) 527-3290 ◆ FAX (509) 527-3264
<i>Whatcom County Health Department</i>	Post Office Box 935 (1500 N. State Street) Bellingham, Washington 98227	(360) 738-2522 ◆ FAX (360) 676-6729
<i>Whitman County Health Department</i>	Public Services Building North 310 Main Street Colfax, Washington 99111	(509) 397-6280 (Colfax) (509) 332-6752 (Pullman) ◆ FAX (509) 397-6239:
<i>Children's Village - Yakima</i>	3801 Kern Road Yakima, Washington 98902	(509) 574-3260 ◆ FAX (509) 574-3210

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How to Complete the HCFA-1500 Claim Form

Important!

Guidelines/Instructions:

- Use only the original preprinted red and white HCFA-1500 claim forms (version 12/90 or later, preferable on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA 1500 claim forms.
- Do not use red ink pens (use black ink for the circle “XO” on crossover claims), **highlighters**, “**post-it notes**,” or **stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, “REBILL,” “TRACER,” OR “SECOND SUBMISSION” on the claim form.
- Use **standard typewritten fonts** that are 10 c.p.i. (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- Use **upper case** (capital letters) for all alpha characters.
- Use **black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded.**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form.** MAA does not accept “continued” claim forms. If more than six detail lines are needed, used additional claim forms.
- **Show the total amount for each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form; **total each claim form.**

Field Description/Instructions

1a. Insured's ID No.: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current monthly Medical IDentification card and consists of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this:
J-100257LEE B.

2. Patient's Name: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. Patient's Birthdate: Required. Enter the birthdate of the Medicaid client.

4. Insured's Name (Last Name, First Name, Middle Initial): When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. Patient's Address: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. Other Insured's Name: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

- 9a.** Enter the other insured's policy or group number *and* his/her Social Security Number.
- 9b.** Enter the other insured's date of birth.
- 9c.** Enter the other insured's employer's name or school name.
- 9d.** Enter the insurance plan insured's health maintenance organization, private

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

- | | |
|---|---|
| <p>10. <u>Is Patient's Condition Related To:</u> Required. Check <i>yes</i> or <i>no</i> to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in <i>field 24</i>. <i>Indicate the name of the coverage source in field 10d</i> (L&I, name of insurance company, etc.).</p> <p>11. <u>Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:</u> Primary insurance. When applicable. This information applies to the insured person listed in <i>field 4</i>. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.</p> <p>11a. <u>Insured's Date of Birth:</u> Primary insurance. When applicable, enter the insured's birthdate, if different from <i>field 3</i>.</p> <p>11b. <u>Employer's Name or School Name:</u> Primary insurance. When applicable, enter the insured's employer's name or school name.</p> <p>11c. <u>Insurance Plan Name or Program Name:</u> Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (<i>Note: This may or may not be associated with a group plan.</i>)</p> | <p>11d. <u>Is There Another Health Benefit Plan?:</u> Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i>. If yes, you should have completed <i>fields 9a-d</i>. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i>. If 11d is left blank, the claim may be processed and denied in error.</p> <p>17. <u>Name of Referring Physician or Other Source:</u> When applicable, enter the primary physician.</p> <p>17a. <u>ID Number of Referring Physician:</u> When applicable, enter the 7-digit MAA-assigned primary physician number.</p> <p>19. <u>Reserved for Local Use:</u> When applicable, enter:</p> <ul style="list-style-type: none"> • “B” - Baby on parent’s PIC; or • When billing for children, the EPA number or prior authorization number. <p>21. <u>Diagnosis or Nature of Illness or Injury:</u> When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.</p> <p>22. <u>Medicaid Resubmission:</u> When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the claim number listed on the Remittance and Status Report.)</p> |
|---|---|

23. Prior Authorization Number:

When applicable. Use the prior authorization number assigned to you if/when services have been denied and you are requesting an exception to policy.

For children: The CSHCN coordinator's stamp (see Sample Claims 2 and 3) and signature must be indicated here. **The EPA number or prior authorization number must be entered into field 19.**

DEPARTMENT OF HEALTH/CSHCN COORDINATOR
X _____

**24. Enter only one (1) procedure code per detail line (fields 24A - 24K).
If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. Date(s) of Service: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403).

24B. Place of Service: Required. These are the only appropriate code(s) for this billing instruction:

Code To Be Used For

11	Office/Ambulatory Surg Ctr
32	Nursing facility (formerly ICF)
31	Nursing facility (formerly SNF)

24D. Procedures, Services or Supplies CPT/HCPCS: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. Diagnosis Code: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. \$ Charges: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. **Do not include dollar signs or decimals in this field.** Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. Days or Units: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. Federal Tax ID Number: Leave this field blank.

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due:** Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #:** Required. Put the *Name*, *Address*, and *Telephone #* on all claim forms.

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)			MEDICAID <input type="checkbox"/> (Medicaid #)			CHAMPUS <input type="checkbox"/> (Sponsor's SSN)			CHAMPVA <input type="checkbox"/> (VA File #)			GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>			FECA BLK LUNG (SSN) <input type="checkbox"/>			OTHER (ID) <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY M F						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																	
CITY						STATE						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY						STATE											
ZIP CODE						TELEPHONE (Include Area Code) ()						Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE						TELEPHONE (INCLUDE AREA CODE) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F						c. EMPLOYER'S NAME OR SCHOOL NAME						d. INSURANCE PLAN NAME OR PROGRAM NAME											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE												17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____												23. PRIOR AUTHORIZATION NUMBER																							
24. A DATE(S) OF SERVICE. From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																			
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4																																			
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						28. \$ TOTAL CHARGE						29. \$ AMOUNT PAID						30. \$ BALANCE DUE					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____																	

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DO NOT
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PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)			MEDICAID <input type="checkbox"/> (Medicaid #)			CHAMPUS <input type="checkbox"/> (Sponsor's SSN)			CHAMPVA <input type="checkbox"/> (VA File #)			GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>			FECA BLK LUNG (SSN) <input type="checkbox"/>			OTHER (ID) <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																	
CITY						STATE						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY						STATE											
ZIP CODE						TELEPHONE (Include Area Code) ()						Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE						TELEPHONE (INCLUDE AREA CODE) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____											
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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE												17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
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